GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUDIT OF UNUSUAL INCIDENT REPORTING PROCEDURES AT THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH

CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

OIG No. 01-1-06RM(c) **June 19, 2003**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

Inspector General

June 19, 2003

Martha B. Knisley
Director
Department of Mental Health
64 New York Avenue, N.E., 4th Floor
Washington, D.C. 20002

Dear Ms. Knisley:

Enclosed is our final report summarizing the results of the Office of the Inspector General's (OIG) Audit of Unusual Incident Reporting Procedures at the District of Columbia Department of Mental Health (OIG No. 01-1-06RM(c)). The Office of the Mayor and the Director of the Department of Mental Health requested the audit. This report also incorporates the results of our Management Alert Report (MAR No. A-02-04) issued on August 20, 2002, concerning compliance with the reporting requirements of D.C. Law 13-104, as amended by D.C. Law 14-70, at Exhibit D.

As a result of our audit, we directed 14 recommendations to the District of Columbia Department of Mental Health (DMH) for necessary action to correct the noted deficiencies. Specifically, our audit disclosed that DMH needs to improve the policies and procedures for managing reports of unusual incidents and its procedures and controls over the security of Saint Elizabeth Hospital patients.

Prior to the issuance of this report, DMH initiated actions to correct several of the deficiencies noted during the audit. On June 4, 2003, we received a response from DMH to the draft report, in which DMH disagreed with some of our conclusions, but concurred with all of the report recommendations and provided us with a corrective action plan and timelines for implementing the recommendations. DMH's response is incorporated at Exhibit C of this report.

If you have questions please contact me or William J. DiVello, Assistant Inspector General for Audit, at (202) 727-8279.

Sincerely,

Charles C. Maddox, Esq.
Inspector General

CCM/ws

Enclosures

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AUDIT OF UNUSUAL INCIDENT REPORTING PROCEDURES AT THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH

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OVERVIEW

The District of Columbia Office of the Inspector General (OIG) has completed an audit of Unusual Incident Reporting Procedures at the District of Columbia Department of Mental Health (DMH) as requested by the Executive Office of the Mayor and DMH.[1] This report is the third in a series of reports that address various functions associated with the delivery of mental health services by DMH. The audit was performed to determine: (1) the adequacy of policies and procedures for documenting, reporting, investigating, and resolving unusual incidents of unexpected deaths, abuse, or neglect of patients in the care of DMH; and (2) the effectiveness of procedures used to secure and account for forensic patients residing at Saint Elizabeths Hospital. Improvements in these areas will strengthen the management and oversight of patient care at St. Elizabeths Hospital and at community residential facilities (CRFs).

On August 20, 2002, we issued a Management Alert Report (MAR No. A-02-04) to alert the Director, DMH about the failure of community residence facilities to submit reports of unusual incidents to the OIG. See Exhibit D. This reporting requirement was established in D.C. Law 13-104, as amended by D.C. Law 14-70, the Mandatory Autopsy for Deceased Wards of the District of Columbia and Mandatory Unusual Incident Report Temporary Act of 2001, which expired on October 10, 2002. Subsequently to issuing the MAR, the OIG and DMH agreed to postpone comment on the issues addressed in the MAR until completion of the audit work and issuance of the draft report.

Perspective

The transition from institutionalized to community based mental health care in the District has been an on-going challenge since 1987. DMH and its predecessor, the Commission on Mental Health Services (CMHS) were given the difficult task of providing consistently high quality mental health services to District residents within the setting of institutionalized and community-based care. CMHS and DMH both were required to oversee the program of care in community-based organizations. This responsibility has been historically seamless and was not a new responsibility that arose with the creation of DMH. However, the oversight program under CMHS was ineffective. With the demise of CMHS and a period under which the District's mental health program operated under a receiver, the newly created DMH faced organizational, structural, and fiscal problems in recasting the District's mental health program. While our report is problem oriented, it is necessary to keep the findings and recommendations in context. Although the problems are not isolated, they are not universal. This report is

[1] DMH is a relatively new agency in the District of Columbia. A brief historical perspective of DMH is provided in the background section of this report.

EXECUTIVE DIGEST

intended to provide insight into several aspects of DMH's operations, with particular emphasis being placed on progress made in overseeing the conduct of community-based care. Our goal is to avoid overstating the importance of individual incidents, as we believe the cases noted in our report are not representative of DMH's overall mental health care service. Rather, our aim is to identify weaknesses and systemic problems identified through examination of incident reports and management's responsiveness to those reports. We also aim to note areas where DMH needs to strengthen policies, procedures and internal controls, especially in the oversight of licensed community residential facilities. Accordingly, our report shows that improvements are needed in several critical management oversight areas and that DMH has been responsive to our call to make these improvements.

CONCLUSION

The policies and procedures used by DMH to document, report, investigate, and resolve unusual incidents of unexpected deaths, abuse, or neglect of DMH patients who are housed in community residential facilities are not effective. Further, the procedures used to secure and account for St. Elizabeth Hospital forensic patients i.e., those patients committed by a court for reasons of insanity need improvement. Specifically, our audit includes the following findings:

- DMH did not always effectively fulfill its oversight responsibilities for the reporting of unusual incidents. More than 500 unusual incident reports were sent to DMH from several sources such as CRF mental health care providers and residential treatment centers for children and youth. However, most of these reports were simply filed away. Reports included incidents such as suicides, patient abuse, sexual assaults, deaths from specified and unspecified causes, and many other types of incidents. Not all incident reports were of such serious import and involved incidents such as patient fights or verbal abuse. While we recognize that the newly created DMH began operating in April 2001, we found little evidence that DMH performed investigations or took action to follow-up on reports of unusual incidents. Further, DMH did not request additional information on reported incidents, although many reports indicated a need for assistance, intervention, or follow-up actions, and many resulted in tragic outcomes.

  Additionally, DMH needs to improve its procedures and controls to provide the extra security necessary for civilly committed and mentally ill patients. Security weaknesses at Saint Elizabeths Hospital allowed more than 100 mentally ill patients to flee the campus on unauthorized leave. Consequently, some of the District's mentally ill patients are being placed at risk of abuse, neglect, and even death in the absence of the extra level of security and care that is needed to protect them.

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- DMH procedures for reviewing and approving mortality reviews are not current. Mortality reviews were not performed for 27 of 80 patient deaths, and those reviews that were performed were untimely. These reviews are necessary to adjudicate and account for patient deaths and to avoid possible costly litigation expenses and potential law suits. Further, autopsy reports and death certificates, which were needed to determine the cause of death in compliance with regulations, were seldom obtained.

- Records show that the whereabouts of more than 20 forensic patients, who are not allowed to leave St. Elizabeths Hospital, are currently unknown. Accordingly, DMH records indicate that bench warrants were requested for these patients. However, there was no documentation on file to indicate that any action had been taken by DMH to determine the disposition of the bench warrants, nor was there documentation on whether the bench warrants were actually issued. As a result, DMH cannot account for more than 20 forensic patients who have been missing more than 20 years.

SUMMARY OF RECOMMENDATIONS

We addressed 14 recommendations to the Director, DMH that we believe are necessary to correct the deficiencies noted above. Those recommendations are as follows:

1. Create an oversight mechanism (committee) or internal audit team to monitor the efforts of the Office of Accountability (OA) to ensure that the unusual incident reporting system is operating effectively. Monitoring efforts should include monthly reports to the Director, DMH.

2. Develop and implement performance standards for the OA.

3. Develop procedures to ensure that the OA reports, investigates, and resolves all unusual incident reports in a timely manner.

4. Take corrective action against providers who do not report unusual incidents in a timely manner.

5. Develop and implement a computerized database to document and track all reports of unusual incidents.

6. Review and evaluate security procedures at Saint Elizabeths Hospital to ensure the safety and security of mentally ill patients.

7. Revise the CMHS policy 50000.115.3E to require periodic reviews of mortality review reports.

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8. Develop and implement procedures to ensure that all deaths are investigated and mortality review reports are timely performed and properly completed.

9. Initiate procedures and assign responsibility to ensure root cause analyses are performed on all unexpected occurrences involving death or serious psychological injury.

10. Require OA to report the completion status of all mortality reviews to Director, DMH on a monthly basis.

11. Require all operators of community residence facilities to retroactively report, for the time period in which the law was in effect, all unusual incidents as required and defined by D.C. Law 13-104 (from April 3, 2001 to November 14, 2001) and D.C. Law 14-70 (from February 27, 2002 to October 10, 2003, to the Inspector General of the District of Columbia.

12. Revise the mortality review report to reflect current organizational responsibilities.

13. Establish procedures to confirm the issuance of all bench warrants requested for forensic patients on unauthorized leave or to request the issuance of new bench warrants where appropriate.

14. Negotiate a memorandum of understanding with the U.S. Attorney's Office and the Office of Corporation Counsel to confirm the issuance of bench warrants and to provide dates and case numbers for all bench warrants issued.

MANAGEMENT RESPONSE AND OIG COMMENTS

On June 4, 2003, DMH provided a formal response to the recommendations in the draft audit report. In its response, DMH disagreed with some of our conclusions, the references we made to the perceived need for added security, and our opinion on the need for required mortality reviews. However, DMH fully concurred with all of the report recommendations, taking aggressive action to address the reported deficiencies, and providing us with a corrective action plan and timelines for implementing the recommendations. DMH's response is incorporated in Exhibit C of this report. DMH also provided several attachments in their response to the draft report, which were not incorporated into this report. These attachments were (1) DMH 480, Unusual Incident Reporting Policies, (2) DMH Memorandum to Providers – Tracking Unusual Incident Reports and (3) Correspondence on Mandatory Autopsy for Deceased Wards of D.C. Copies will be provided upon request.

A summary of potential benefits resulting from this audit is included at Exhibit A.

EXECUTIVE DIGEST

INTRODUCTION

BACKGROUND

Historical Perspective. In February 1974, a group of patients committed to Saint Elizabeths Hospital filed a class action lawsuit against the federal government and the District of Columbia government. At the time, the federal government operated Saint Elizabeths Hospital and the District government operated District community-based mental health centers. The plaintiffs brought the suit in an effort to obtain community-based mental health treatment where their respective mental illnesses did not require hospitalization. As a result of the suit, the federal court ruled in December 1975 (in what is known as the "*Dixon* Decree") that the federal and District governments were jointly responsible for providing community-based treatment in the least restrictive means where medically appropriate.

When the federal government transferred Saint Elizabeths Hospital to District control in 1987, the District government consolidated mental health services under a new agency, the Commission on Mental Health Services (CMHS). In June 1997, federal court placed CMHS into receivership based upon its finding that the District had failed to comply with the requirements of the *Dixon* Decree. The federal court approved the receiver's plan to develop an integrated, comprehensive, and cost-effective community-based plan for mental health services in the District.

While the District's mental health services came out from under the auspices of the receiver in May 2002 the department of Mental Health (DMH) began operating under its director in May 2001. On December 18, 2001, the District of Columbia Council officially established the DMH as the successor agency to the CMHS through the Mental Health Service Delivery Reform Act of 2001, D.C. Law 14-56.[2] The DMH was established as a District agency that is subordinate to the Mayor, but with independent personnel and procurement authority. *Id.* at § 103.

DMH Mission/Programs. The overall mission of DMH is to develop, support, and monitor an effective and integrated community-based system of services for persons with identifiable mental health needs. The fiscal year 2002 budget for DMH was $227 million, and for fiscal year 2003, the budget is estimated at $229 million. DMH provides mental health services and workforce development programs for approximately 7,000 patients through the following control centers:

- **Mental Health Authority** is the part of the DMH organization that oversees the District's mental health system. Functions of the authority include: quality improvement, planning and policy development, delivery systems management, fiscal and information services, patient relations, government relations, and public relations.

[2] D.C. Law 14-56 is currently codified at D.C. Code §§ 7-1131.01 to 7-1-1231.14 (2002 Supp.).

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The mental health authority monitors and inspects 167 community residence facilities housing approximately 800 patients**.** These facilities are operated under licensure to DMH.

Rules governing the operation of community residence facilities for mentally ill persons are set forth in Chapter 38 of Title 22 of the District of Columbia Municipal Regulations (DCMR). A community residential facility is a licensed, publicly or privately owned residence, that houses individuals 18 years or older, diagnosed with a mental illness, who require a 24-hour on-site supervision, personal assistance, lodging and meals. 22 DCMR § 3800.2. Community residential facilities provide a specific level of health care in a safe, hygienic, protective/sheltered living arrangement for one or more individuals who are able to perform daily activities with minimal supervision. *Id*. § 3099.1. Currently, the DMH does not operate any publicly owned community residential facilities.

- **Saint Elizabeths Hospital** is the DMH-operated facility that provides a variety of inpatient mental health services to District residents. Included in these services is the Forensic Services Division, which provides forensic staff training and advanced research initiatives to constantly improve evaluation and treatment methodologies. It also collaborates with the District government, the courts, and criminal justice agencies on pre- and post-booking jail diversion alternatives.

- **The Community Services Agency** is the DMH-operated outpatient provider of core services, specialty services, and other DMH-funded services to patients in the District.

- **Community Providers** focus on reducing utilization of facility-based services and out-of-home placements and provide crisis/emergency services, community-based interventions, rehabilitation programs, partial hospitalizations, and assertive community treatment. DMH also contracts for various residential, vocational, and advocacy services that support children, youth, and their families. Community residential facilities are licensed to provide housing for District residents who require 24-hour supervision and assistance with activities of daily living.

OBJECTIVES, SCOPE, AND METHODOLOGY

The overall objectives of the audit were to determine: (1) the adequacy of policies and procedures for documenting, reporting, investigating, and resolving unusual incidents of unexpected deaths, abuse, or neglect of patients in the care of DMH; and (2) the effectiveness of procedures used to secure and account for criminally committed patients residing at Saint Elizabeths Hospital.

To accomplish our objectives, we interviewed DMH's management and administrative staff, including officials responsible for handling unusual incident reports, to gain a

INTRODUCTION

general understanding and an overview of the policies and procedures used to manage unusual incidents. We obtained copies of laws, applicable regulations, policies, and procedures related to the administration and disposition of unusual incident reports. We also reviewed unusual incident reports, investigation reports, mortality review reports, and other related documents.

We obtained information from the United States Attorney's Office for the District of Columbia on the disposition of bench warrants that were requested for 30 criminally committed patients. In addition, we obtained information and conducted discussions with officials of the District of Columbia Office of the Chief Medical Examiner.

The audit covered unusual incident reports for the period June 1, 2001, to June 30, 2002. Audit fieldwork concluded in December 2002. We conducted the audit in accordance with generally accepted government auditing standards, and included such tests, as we considered necessary under the circumstances.

FINDINGS AND RECOMMENDATIONS

FINDING 1: DOCUMENTING AND RESOLVING REPORTS OF UNUSUAL INCIDENTS

SYNOPSIS

DMH did not always follow its established policy for managing more than 500 reports of unusual incidents, which identified unanticipated deaths, abuse, or neglect of the District's mentally ill patients.[3] Specifically, DMH did not perform investigations or take appropriate actions to follow-up on reported incidents as prescribed by DMH policy. DMH also had not developed and implemented the detailed procedures and guidelines necessary to manage reports of unusual incidents, nor had reports of unusual incidents been properly recorded in DMH databases. The information in the reports was incomplete, unreconciled, and, therefore, ineffective as a management tool. Factors contributing to these conditions include DMH's failure to follow its own policy and insufficient management oversight.

Additionally, DMH needs to improve its procedures and controls to provide the extra security needed for civilly committed and mentally ill patients to ensure that they are provided protection from abuse, neglect, and even death. For example, as described more fully below, we found that for the one year period ending June 30, 2002, more than 100 mentally ill patients, many civilly committed, fled Saint Elizabeths Hospital campus on unauthorized leave.

DISCUSSION

DMH Policy On Unusual Incidents. DMH's policy for managing unusual incidents is contained in DMH Notice 480, dated May 9, 2002. The policy applies to DMH Community Service Agencies (CSA), Saint Elizabeths Hospital, Community Residence Facilities (CRF), and all other providers of mental health services that are licensed or certified by DMH. The policy establishes the Office of Accountability (OA) as the central location for notification of all unusual incidents and for ensuring that appropriate actions are taken. The OA also maintains pertinent information and copies of written reports on unusual incidents.

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[3] CMHS Policy 50000.480.2, Paragraph 7a defines "unanticipated death" as:

> (1) Death of a CMHS hospitalized consumer while on a CMHS ward or at another facility to which the consumer was transferred for medical/psychiatric care;
> (2) Death of a consumer served in the community; and
> (3) Any known death of any former CMHS consumer that occurs within 30 days of discharge.

As DMH uses the terms "unanticipated death" and "unexpected death" interchangeably, the terms will be used interchangeably throughout this report.

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Paragraph 5 of the policy defines an "unusual incident" as "[a]ny event that poses a danger to the health and safety of consumers or staff," or an event that is "not consistent with the routine care of consumers or routine operations" of the mental health provider. The policy also requires OA to request follow-up reports, investigate all major unusual incidents, and ensure appropriate actions are being taken. Further, DMH Notice 480 requires incident reports to be immediately filed with the OA for the following types of incidents:

- unexpected death of a consumer or the death of a staff person on duty;
- serious bodily injuries such as broken limbs, any injury that requires transfer to a medical facility for treatment, or suspicious injuries whether or not medical treatment is required;
- abuse or neglect; and
- incidents or potential incidents that put individuals at risk of serious injury or death or in which a claim or lawsuit may be filed against DMH.

Finally, the policy requires mental health providers to maintain logs of all unusual incidents, detailing the number, incident date and type, the date the incident was reported to OA, immediate administrative actions taken, and the final outcome.

Review of Unusual Incident Reports at the OA. Our review of the major unusual incidents, that were included in the 508 unusual incident reports during the one-year period ending June 30, 2002, identified many incidents that were in urgent need of investigation and indicated that other incidents had not been reported. We organized the results of our review of these incidents into three categories: (1) unexpected deaths; (2) assaults and abuse; and (3) eloped, missing, and escaped high-risk patients.[4] Exhibit B contains a summary listing of all 508 incidents. In the list we identified 9 unexpected deaths, and 37 unspecified deaths, 124 instances of alleged assaults or abuse and 67 instances of missing persons, escapes, or elopements. In addition, we found unusual incident reports for 67 patient injuries, 71 hospitalization or medical care needs, 28 suicide attempts or gestures and 95 other unusual incidents.

Unexpected Deaths. Mental health providers are required to report unexpected deaths to OA, and OA must ensure that the necessary investigations are conducted. However, in most cases, OA's database did not identify the type of death as either expected or unexpected, even though the incident reports provide this information. For example, for the one-year period ending June 30, 2002, OA's database indicated that a total of 56 patient deaths

[4] DMH uses a variety of terms, including unauthorized leave, missing person, escaped, and elopement, to describe patients who cannot be located because they either do not return from authorized leave or simply disappear.

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occurred, but the type of death in 37 instances was unspecified and simply indicated as "death."

Our review of incident reports for unexpected deaths and suicides disclosed numerous incidents in which inadequate follow-up actions were taken. During this process, we identified other unusual incidents that went unreported and instances where additional attention to patient needs may have resulted in different outcomes. Examples of inadequate follow-up action or lack of incident reporting follow:

- On June 25, 2001, a community residential facility (CRF) operator was advised of a patient's attempted suicide. The attempted suicide was confirmed on June 25, 2001, when a fireman gained entry and found the patient, who admitted to taking painkillers, illicit drugs, and drinking a fifth of alcohol. Records also indicate that the patient admitted to attempting suicide on two prior occasions. Rather than initiating action to have the patient civilly committed for evaluation, the CRF operator reported that there was "no evidence she had attempted to harm herself so she could not be taken involuntarily to a hospital." In addition, the CRF failed to prepare an unusual incident report for this incident.

  On August 6, 2001, a police detective found the patient dead after responding to a call from a neighbor who reported an odor coming from the patient's apartment. The provider did not prepare the unusual incident report for this event until 21 days later, on August 27, 2001. OA's database did not specify the type of death as "unexpected." It identified the incident only as a "death" and not as an "unexpected death."

  Furthermore, OA had no documentation to indicate that the caseworker had any contact with the patient subsequent to June 25, 2001. The exact date of her death was not determined nor was a mortality review performed to ascertain the cause of death or to examine clinical findings that could identify potential problems or opportunities to improve patient care.[5] Finally, OA had no documentation to indicate that DMH obtained an autopsy report from the Office of the Chief Medical Examiner.

- On August 3, 2001, at 8:35 pm, the roommate of a 48-year-old female patient left a concerned voice mail message with the patient's health care supervisor, advising health care officials that her roommate had isolated herself in her bedroom for the past 3 weeks. The health care supervisor did not call the patient until 3 days later on August 6, 2001, at 5:45 pm, and there was no answer. Another call was placed at 8:30 pm, but again there was no answer. Finally, the health care supervisor arrived on August 6, at 9:25 pm.

  Upon arrival, the health care supervisor and other staff forced the door open and found the patient on the floor, unconscious but breathing. Paramedics transported her

[5] A mortality review is designed to identify systemic issues that may have contributed to a patient's death. Finding 2 of this report contains a more detailed discussion on mortality reviews.

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to the hospital, but she died en route. On August 8, 2001, the contract provider and a representative from the coroner's office concluded that bruises on the patient's back revealed that she had been hit with a pipe and that "she was probably assaulted on the street, went home and did not reveal it to anyone."

OA had no documentation to indicate an investigation was performed to determine whether the patient had been confined to her room for 3 weeks or to discern the reason it took 3 days, from the evening of August 3, 2001, to the evening of August 6, 2001, for the health care supervisor to respond. There was no determination that she died of wounds attributed to the alleged assault or whether she died from some other cause.

The incident report indicated the patient had been "down for a couple of days." The incident report further indicated it would be several weeks before a conclusive determination of the cause of death could be reached. Both the unusual incident report and the OA's database identified the death only as a "death" and neither specified the type of incident as an "unexpected death" as contemplated by DMH Notice 480. Ultimately, there was no indication that the cause of death was ever obtained from the coroner's office.

- An unusual incident report, dated January 28, 2002, reported the death of a 46 year-old female patient who died on January 27, 2002. The report indicated the patient apparently fell on the floor in her CRF, experienced breathing difficulties, and was taken to a local hospital on January 24, 2002. An unusual incident report was not prepared for the January 24, 2002 incident. She returned to the CRF on January 25, 2002, experienced additional breathing difficulties and was returned to the local hospital, where she died on January 27, 2002.

  The Death Information Report indicated that the exact cause of death was unknown and that a death certificate had been requested.[6] However, there was no indication that the death certificate had been obtained. In addition, auditors could find no indication of any investigation by the CRF to determine how the fall occurred, and if her death could be attributed to the fall.[7]

- A CRF incident report dated February 8, 2002, notified the OA of a CRF patient's death. The report indicated that the patient had a laceration on his head and died, but did not determine the cause of the death. Homicide detectives investigated the incident, and on February 28, 2002, the D.C. Metropolitan Police Department

[6] The Death Information Report is part of the patient's discharge report and summarizes information on the date, time and cause of death.

[7] This CRF resident died in a local hospital as a direct result of an incident that occurred at the CRF. However, an autopsy, required by policy for all unexpected patient deaths that occur in a CRF, was neither requested nor performed. CMHS Policy 50000.382.1E, 8a requires that autopsies be performed on patients who die away from Department facilities and were hospitalized less than 72 hours, and for patients who die with no prior medical condition.

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announced the Medical Examiner ruled the death a homicide. In response to that announcement, the CRF provider submitted a report to the Community Services Agency (CSA) that described the event and also detailed the patient's medical history for the year prior to his death. The report indicated that on seven prior occasions the patient sustained injuries, including bruises to his right arm, left arm, forehead, left eye, and nose. The report did not provide details but indicated that clinical notes made reference to known incidents that had taken place involving the patient. The notes were not provided as part of the report because of the "voluminous" logbook, but the report indicated that the notes could be reviewed at the CRF office. None of the seven prior occasions that resulted in injuries to the patient were reported to the OA by the CRF. Even after being advised of the prior documented injuries, there was no indication that DMH officials reviewed the logbook of these incidents.

There was no indication that any actions were taken by DMH against the CRF for failing to report the prior incidents. Auditors were informed that one of the CRF employees has been indicted for the February 8, 2002, incident.

Assaults and Abuse. The OA's database contained a total of 124 reports of alleged assaults and abuse. Our sampling of some of these reports where OA did not take the actions needed to investigate and resolve critical issues follows.

- On November 16, 2001, a patient contacted DMH, Consumers Rights Division (CRD), alleging that she was harassed by staff, constantly put in seclusion for no apparent reason, and treated like a prisoner instead of a patient. CRD initiated an investigation and on January 15, 2002, forwarded a report to the OA on the results of its investigation. The CRD report indicated that an incident report had not been prepared until 14 days after CRD initiated its investigation, and concluded that the patient's complaint should have been handled as a case of alleged abuse, but was not, thereby violating the patient's consumer rights.

  The seven-page CRD report supported the patient's complaint of being placed in seclusion, up to 5 hours, in violation of Saint Elizabeths Hospital policy, and raised numerous other issues of concern.[8] The CRD report also requested that the OA respond to all of the issues raised in the report. However, we could find no evidence that OA responded to these concerns.

- A 32 year-old female patient reported to the CRF operator that she had been involved in sexual activity with a staff member for several months. On September 25, 2001, the DMH Homeless Services Coordinator requested that several offices, including the Consumer Affairs Office, follow-up on the report.

[8] CMHS Policy 50000.311.1F, "Restraints and Seclusion", dated December 30, 1999, §6, sets forth Commission-wide policy and prohibits the use of restraints and seclusion "as a part of a treatment plan, for the convenience of staff, or for the purpose of punishment…."

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On October 4, 2001, a representative from the Consumer Affairs Office faxed the original unusual incident report to the OA and commented:

> I received this UI report and contacted . . . she informed me of a directive from your office to forward UI reports to your office. I am concerned about . . . the consumer's right to be free of sexual abuse and other ethical issues. I am not sure if this office no longer investigates allegations . . . from the community.

There was no evidence or documentation to show that the OA investigated the incident or that any action was taken against the CRF staff member. Further, there was no response by the OA to the Consumer Affairs Office's specific request dated October 4, 2001.

- On January 24, 2002, Child and Family Services Agency forwarded an investigations report to OA that indicated they had received a report that alleged residents at a contract facility were subjected to neglect (e.g., forced to sleep on the floor at night), threatened by staff, denied proper care, and left in unsanitary conditions. In addition, the report alleged that several children were improperly restrained at the facility and that one child had a visible injury on her lip as a result of being physically restrained by a staff member. At the conclusion of the investigation, Child and Family Services substantiated the allegations of physical abuse only. The report concluded, "the level of risk is determined to be high."

  Notably, an unusual incident report was never prepared; however, the investigative report was sent directly to the service provider with a copy forwarded to OA, but OA had no documentation to indicate it followed up with the provider or that the provider responded to the report. Further, there is no evidence or documentation to show that DMH took any action against the service provider for the abusive care of a child.

- A 37 year-old deaf female alleged she was sexually assaulted, and a subsequent hospital examination confirmed there was evidence of an assault. A report, "Plan of Corrective Action," had been prepared for the CSA's Risk Management Office the following day that indicated some contradictions regarding the identity of the assailant. The report also disclosed that more definitive information would be sought regarding the location of the incident, whether the parents were notified, and the identity of the assailant.

  We could find no evidence of any further investigation by OA and there were no records available at DMH to indicate that a police report was prepared.

- An unusual incident report was prepared on November 6, 2001, for an 81 year-old female patient at Saint Elizabeths Hospital who was attacked by another patient. The patient was struck repeatedly about the head and face, and the ambulance was called.

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An unusual incident report was prepared that discussed the patient's injuries. The unusual incident report did not mention the assault by the other patient.

We could find no evidence the OA took any further action to identify the cause of the patient's injuries, and there was no indication that a police report was prepared or that some form of restraint or restrictive care was placed on the aggressive patient.

- A DMH inspections team visiting a CRF on March 25, 2002, learned that a patient, who should have been residing at the CRF, had been placed in a nursing home about 2 months prior (on January 15, 2002). The inspection team was informed that the patient had fallen in the CRF and sustained a broken leg.

  There was no documentation at the OA that the CRF reported the incident. The CRF, at the request of the Inspection team, faxed an incident report on April 10, 2002. The CRF did not enter the date the incident occurred, as required on the report, but dated and signed the report January 1, 2002. There was no entry below line 15 on the form, which required the provider to indicate whether the OA had been notified. From all appearances, this was the first reporting of the incident.

  The belated unusual incident report indicated the patient fell while getting up from the dinner table. The inspection report indicated that the CRF's resident manager accompanied the patient to the doctor's office, where a break in the patient's leg was discovered and that the patient was admitted on January 3, 2002, to the Washington Hospital Center for surgery.

  The DMH inspection report recommended that the CRF be required to provide: (1) clear documentation on the circumstances surrounding the accident; (2) a plan to correct gaps in service; (3) documentation training for all staff; and (4) training in unusual incident reporting. The file lacked documentation to indicate whether the report was formally transmitted to the CRF or whether any of the recommendations were implemented. Also, if the incident occurred on January 1, 2002, as indicated on the CRF's report, there was no explanation as to why it took 2 days for the CRF's resident manager to transport the patient to the doctor's office.

DMH, Office of Accountability. Based on our review of records, we determined that OA had not yet implemented the policies and procedures contained in DMH Notice 480 that were needed to ensure that unusual incidents were documented, reported, investigated, and resolved. In addition, an effective oversight mechanism and performance standards for managing or investigating reported incidents had not been established for the OA.

We reviewed and analyzed the OA's correspondence files on 508 reports of unusual incidents some of which involved unexpected deaths and alleged patient abuse or neglect during the one-year period ending June 30, 2002. We found little evidence or documentation to suggest that the OA initiated investigative action on unusual incident reports. Although

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the OA provided our Office with 29 follow-up reports, these reports were initiated by providers of mental health services who were licensed or certified by DMH and did not appear to be the result of an OA investigation or request for information.

Actions taken by the OA on reported unusual incidents consisted of entering details of the incidents (patient numbers, dates of incidents, types of incidents, etc.) into an automated database and maintaining copies of the reports in notebooks. We found little evidence that additional action was initiated by the OA. Although the OA established a computerized database of unusual incidents, the database had not been used as a management tool for analyzing and identifying systemic problems. Moreover, the current status of reported incidents could not be determined from the database.

DMH Databases For Unusual Incident Reports. DMH Notice 480 requires the CSA and Saint Elizabeths Hospital to log all unusual incidents. The log (also referred to as a database) must include the: (1) patient identification number; (2) incident date; (3) type of incident; (4) the date the incident was reported to OA, if applicable; (5) immediate administrative actions taken; and (6) outcome or final result. We reviewed the database of unusual incidents at the OA, the CSA, and Saint Elizabeths Hospital and found that DMH's three databases on unusual incident reports were incomplete and incompatible. We also discovered that the OA, the CSA, and Saint Elizabeths Hospital established a different type of database. The OA maintained its reports in a Microsoft Access software database, while CSA used a Microsoft Excel spreadsheet, and Saint Elizabeths Hospital relied on a mainframe computer. Both software databases had different data fields. Therefore, none of the three databases contained compatible information nor were they uniform. The incompatible databases prevented reconciliation of the information maintained at the three locations to ensure their completeness.

The incompatible databases also created additional burdensome staffing requirements for OA personnel. Each of the 508 incidents reported to OA required OA personnel to manually input the information into its database. Standardized databases or software systems would have allowed electronic updates, ensured the compatibility of data at all three locations, and allowed necessary reconciliations of information.

We likewise discovered that the databases at the OA and CSA did not contain all necessary information. OA's database of 508 incidents for the 12-month period ending June 30, 2002, did not contain the patient identification number for more than 300 incidents (about 60 percent). The OA database also did not contain information indicating either the current status or the action taken on the reported incidents.

CSA's database contained 172 entries at the time of our initial review. However, the type of incident had not been entered for 58 incidents, and the corrective action taken was not indicated in more than half of the reported incidents. In order to determine the current status of the incidents, we requested that CSA personnel update their database, which they did. When we reviewed CSA's updated database, we noted that the revised database now showed

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201 incidents, 29 more than had been originally entered in CSA's database at the time of our initial review.

Security Over High-Risk Patients. DMH had not implemented procedures and safeguards needed to provide the extra level of security necessary to prevent high-risk patients from fleeing the confines of Saint Elizabeths Hospital. A number of high-risk patients, who had been civilly committed to Saint Elizabeths Hospital, fled the Saint Elizabeths Hospital campus on unauthorized leave during the period October 1, 2001 to June 30, 2002.

Missing High-Risk Patients. For the one-year period ending June 30, 2002, OA's database indicated that 67 patients had been reported as eloped, missing, or absent without leave. However, the database did not reflect the true extent of the problem or the number of patients who were missing. Our analysis of the unusual incidents reported by Saint Elizabeths Hospital for the same period identified 126 additional patients who had been missing and placed on unauthorized leave but who were not reported in OA's database.

Based upon our analysis, we concluded that patients appear to be acutely aware of the security weaknesses because there have been repetitive elopements by many patients. For example, for the 126 instances identified above, 70 were committed patients. Of the 126 instances, 25 patients had escaped more than once, 3 were reported missing at least 4 times, and a civilly committed patient was reported missing 10 times in a 10-month period. A notation on one of the incident reports for this civilly committed patient indicated, "patient known for elopements to drink alcohol and do drugs." She left the premises without authorization four additional times subsequent to that notation. The current whereabouts of many of the patients are still unknown.

The continued large number of missing patients from Saint Elizabeths Hospital increases the potential for future tragic incidents. During our audit, we identified two civilly committed patients whose elopements resulted in their untimely and unfortunate deaths. One patient, while on unauthorized leave from Saint Elizabeths Hospital, committed suicide. The other, committed to Saint Elizabeths Hospital because she refused to take her medicine, eloped and was found unconscious on the streets of the District of Columbia. Her death on December 22, 2001, was attributed to hypothermia from exposure to the cold environment. However, despite the high-risk concerns associated with these patients, DMH has not taken the steps necessary to identify high-risk patients and to institute measures needed to protect both the high-risk patients and the community from harm.

During our audit, we also identified another patient who, on December 19, 2001, was brought to Saint Elizabeths Hospital by the D.C. Metropolitan Police for unruly behavior and admitted for emergency observation. On December 20, 2001, Saint Elizabeths Hospital filed a petition with the Superior Court requesting continued hospitalization for emergency observation for a period of 7 days. On December 26, 2001, Saint Elizabeths Hospital then filed a petition for judicial hospitalization, requesting that the Commission on Mental Health Services (CMHS) continue to detain the patient until a final order was entered. On December 26, 2001, the Superior Court concluded that the patient was mentally ill and,

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because of that illness, was likely to injure himself or others, and ordered the patient to be remanded to Saint Elizabeths Hospital.

A formal hearing for this patient was held January 15, 2002, in the Superior Court. Testimony presented at that hearing indicated the patient became hostile and threatening and required six security guards to escort him to the hearing. Facts were also presented at the hearing describing an incident that occurred during the patient's hospitalization, in which the patient physically attacked and brutally beat a staff member of Saint Elizabeths Hospital. The attack caused serious injury, including facial fractures, a broken nose, and fractured ribs. It was also noted that the staff member would be pressing charges against the patient.

In addition, facts were presented at the January 15th hearing that the patient eloped three times during his hospitalization (Saint Elizabeths only reported two elopements). After the hearing, CMHS concluded that the patient was mentally ill and recommended that the patient be hospitalized as a committed inpatient for an indeterminate period. However, on January 17, 2002, the patient eloped, the fourth time in a period of less than 2 months.

RECOMMENDATION 1

We recommend that the Director, Department of Mental Health create an oversight mechanism (committee) or internal audit team to monitor the efforts of the OA to ensure that the unusual incident reporting system is operating effectively. Monitoring efforts should include monthly reports to the Director, Department of Mental Health.

DMH Response

DMH concurred with the recommendation and plans to create an oversight committee to monitor the efforts of the OA. DMH currently reviews incidents on a monthly basis in the DMH Risk Management Committee. OA/Division of Quality Improvement has prepared a template for reporting unusual incidents to risk management and will report major unusual incidents to the Risk Management Committee.

OIG Comment

We consider DMH's actions to be responsive to our recommendation.

RECOMMENDATION 2

We recommend that the Director, Department of Mental Health develop and implement performance standards and measures for the OA.

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DMH Response

DMH concurred with the recommendation. Performance standards have already been included in OA Deputy Director's performance contract.

OIG Comment

DMH's actions are responsive to our recommendation.

RECOMMENDATION 3

We recommend that the Director, Department of Mental Health develop procedures to ensure that all unusual incidents are timely reported, investigated, and resolved.

DMH Response

DMH concurred with the recommendation and issued major unusual incident reporting policy in December 2002. DMH also plans to hire additional staff for incident investigations.

OIG Comment

DMH's actions are responsive and meet the intent of our recommendation.

RECOMMENDATION 4

We recommend that the Director, Department of Mental Health take corrective action against providers who do not report unusual incidents in a timely manner.

DMH Response

DMH concurred with the recommendation and will take corrective action as appropriate. DMH currently has authority to sanction CRF providers who fail to comply with standards.

OIG Comment

We consider DMH's actions to be responsive and meet the intent of our recommendation.

RECOMMENDATION 5

We recommend that the Director, Department of Mental Health develop and implement a computerized standard database for OA, the Community Services Agency's Risk Management Office, and Saint Elizabeths Hospital, to document and track all reports of unusual incidents.

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DMH Response

DMH concurred with the recommendation and reconfigured the OA unusual incident database to improve unusual incident documentation and tracking capability.

OIG Comment

DMH's actions are responsive to our recommendation.

RECOMMENDATION 6

We recommend that the Director, Department of Mental Health review security procedures, including procedures for authorizing patient leave at Saint Elizabeths Hospital and take the action necessary to ensure the safety and security of mentally incapacitated, high-risk patients.

DMH Response

DMH concurred with the recommendation and is conducting an external review of these procedures.

OIG Comment

We consider DMH's actions to be responsive and meet the intent of our recommendation.

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FINDING 2: MORTALITY REVIEWS AND PATIENT AUTOPSIES

SYNOPSIS

Investigating and evaluating the cause of patient deaths are part of DMH's process for evaluating and monitoring the performance of clinical functions. We found that this responsibility was not fulfilled because patient deaths had not been thoroughly investigated and root cause analysis techniques were not employed. DMH procedures for reviewing and approving mortality reviews were not current. In addition, mortality reviews were not performed on 27 of 80 patient deaths, and when performed, were not performed in a timely manner. Finally, the cause of patient deaths was not always determined because autopsy reports and death certificates were seldom obtained. As a result, DMH failed to comply with established policies, did not properly account for the deaths of patients in its care, and did not take advantage of the opportunities to improve the quality of care.

DISCUSSION

CMHS Policy 50000.115.3E, Mortality Review, dated January 20, 1999, provides DMH mortality review procedures. The policy requires mortality reviews for any death "occurring while the patient is on the rolls of the CMHS." *Id.* at § 9. The procedures are designed to ensure a thorough review of patient deaths and establish "a process for reviewing, monitoring, and reporting the quality of care received by patients in order to identify opportunities to improve care."

The mortality review process is designed to identify systemic issues that may have contributed to a patient's death, which, if not corrected, could contribute to the deaths of others. This review process also seeks to improve clinical performance problems of individual providers. A Mortality Review Report (Form CMHS-368) is used to document all death reviews and supplements the Transfer, Discharge, Death Summary (Form CMHS-2).

Patient Deaths Not Always Investigated. Mortality reviews were not performed in 27 of 80 patient deaths that occurred during the period June 1, 2001, to June 30, 2002. In 2 of the 27 cases, the deaths were attributed to patients who were in an outpatient status. In most cases, the patients either resided in a CRF or were cared for by a contractor provider. Mortality reviews for the 27 patient deaths had not been performed because DMH personnel had not monitored patient deaths to ensure that mortality reviews were completed.

Mortality Reports Not Subjected to Department Level Reviews. CSA and St. Elizabeth Hospital completed 44 and 9 mortality review reports respectively for a total of 53 reports during the test period. None of the 53 mortality review reports were subjected to independent reviews. The Mortality Review Report has five sections and provides for various levels of review and signatures for each as follows:

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- Person completing the review
- CMHS medical director (or contract medical director reviewing the report)
- CMHS bureau director reviewing the report
- CMHS administration senior executive
- Contract agency's chief executive officer
- CMHS clinical director

Instructions for completing the reports are contained in CMHS Policy 50000.115.3E. However, CMHS Policy 50000.115.3E has not been revised to reflect the department's current organizational structure and titles. As a result, none of the 44 CSA and 9 St. Elizabeth Hospital mortality reviews was submitted for Department level review. In addition, the CSA medical director did not sign the Transfer, Discharge, Death Summary Report (Death Summary Report) in seven instances to indicate he had reviewed the reports as required by CMHS Policy 50000.115.3E.

Mortality Reviews Not Always Timely. According to CMHS Policy 50000.115.3E, Mortality Reviews and Death Summary Reports must be forwarded to the medical director within 30 days of the patient's death. Our review of the Mortality Review reports and Death Summary Reports indicated only 2 Mortality Review reports and 10 of the Death Summary reports were completed within the required time frames. The two Mortality Review reports took more than 6 months to complete.

Autopsy Reports and Death Certificates Rarely Obtained. CMHS Policy 500000.115.3E requires mortality reviews for all deaths occurring while the patient is on the rolls of CMHS. In addition, on November 19, 2001, the Council of the District of Columbia enacted two temporary laws, D.C. Law 13-244, the Mandatory Autopsy for Deceased Wards of the District of Columbia and Mandatory Unusual Incident Report Temporary Act of 2000 and D.C. Law 14-70, the Mandatory Autopsy for Deceased Wards of the District of Columbia and Mandatory Unusual Incident Report Temporary Act of 2001. In effect during our test period, these acts required the Chief Medical Examiner or a qualified pathologist to perform an autopsy within 72 hours of a person's death, if the deceased was a ward of the District of Columbia government or a resident of certain residential facilities and had not been diagnosed as terminally ill.

Our review of the 80 patient deaths that occurred during the test period indicated DMH obtained only 8 autopsy reports and only 15 death certificates for patient deaths. CMHS Policy 50000.115.3E also indicates secondary mortality reviews should be performed if autopsy reports are unavailable, but we found no indication that secondary reviews were performed even though autopsy reports were rarely obtained. We also noted that 10 cases had each been ruled a "Coroner's case," but DMH only obtained autopsy reports on two from the Office of the Chief Medical Examiner (hereafter referred to as the Medical Examiner's Office).

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One DMH representative advised us that the Medical Examiner's Office did not always provide autopsy reports but the DMH representative could not provide documentation demonstrating that DMH ever requested an autopsy report. Another DMH representative advised us that DMH had not requested autopsy reports for the past several years because the Medical Examiner's Office charged $12 for each report. However, our subsequent discussions with the Medical Examiner's Office indicated that it does not charge D.C. government agencies for autopsy reports.

Furthermore, information obtained from a responsible official of the Medical Examiner's Office indicated that there is no assurance that all deaths of DMH patients have been reported or that autopsy reports are always requested by DMH. That same official informed us that the District of Columbia Mental Retardation and Developmental Disability Administration routinely notifies the Medical Examiner's Office of patient deaths, but similar notifications are not received from DMH.[9]

Performing Root-Cause Analyses of Patient Deaths. CMHS Policy 50000.115.1G, Organizational Performance, § 1, specifies "DMH's system-wide approach for continuously monitoring, analyzing, and improving performance of clinical [procedures] and other processes to improve consumer outcomes." The policy indicates that all services, disciplines, contractors, and special programs are to be engaged in performance improvement activities. Additional performance goals are to comply with the: (1) Health Care Financing Administration's (currently known as the Centers for Medicare & Medicaid Services (CMS)) Conditions of Participation, and (2) Joint Commission on Accreditation of Health Care Organization's (JCAHO) accreditation standards.

The policy mandates that a root cause analysis (RCA) be performed on all unexpected occurrences involving death, or serious physical or psychological injury, or the risk thereof.[10] The root cause analysis, as defined in CMHS Policy 50000.480.2 Paragraph 5c, identifies the basic or causal factors underlying performance variation and:

> (1) focus[es] primarily on systems and processes, not individual performance, and should not be directly linked to disciplinary actions;
> (2) progress[es] from special cases in clinical processes to common causes in organizational processes; and
> (3) identifi[es] potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determine, after analysis, that no such improvement opportunities exist.

[9] We have requested the Medical Examiner's Office to provide us with autopsy information on the deaths of all DMH patients during the audit period to determine the extent to which DMH has reported the deaths of mentally ill patients to the Medical Examiner's Office. We have not received the requested autopsy information from the Medical Examiner's Office as of the date of this report.

[10] The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. CMHS Policy 50000.480.2 at § 5a.

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We noted that DMH had not taken the actions needed to implement the performance of root cause analyses. None of the patient deaths and none of the assault and abuse cases cited in the first finding of this audit report were subjected to a root cause analysis. As a result, not all aspects of unexpected patient deaths were reviewed, and contributing factors were not considered. In addition, the CMS' Conditions of Participation may be jeopardized by failure to perform root cause analyses.

We believe the issue of monitoring the progress of actions on mortalities in connection with services provided by DMH is sufficiently important that each incident should be tracked until resolved and the status of each brought to the attention of DMH Director, monthly.

RECOMMENDATION 7

We recommend that the Director, Department of Mental Health revise the CMHS policy 50000.115.3E to require periodic reviews of mortality review reports.

DMH Response

DMH concurred with the recommendation and has prepared Incident Investigation Guidelines, Consumer Death Determination procedures and documentation forms, and drafted a new Mortality Review Policy.

OIG Comment

DMH's actions are responsive and meet the intent of our recommendation.

RECOMMENDATION 8

We recommend that the Director, Department of Mental Health initiate the procedures needed to ensure that all deaths are investigated and mortality review reports are timely and complete.

DMH Response

DMH concurred with the recommendation. See DMH actions taken in response to Recommendation # 7 above.

OIG Comment

We consider DMH's actions to be responsive and meet the intent of our recommendation.

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RECOMMENDATION 9

We recommend that the Director, Department of Mental Health initiate the procedures needed and assign responsibility to ensure that root cause analyses are performed as required.

DMH Response

DMH concurred with the recommendation. See DMH actions taken in response to Recommendation # 7 above.

OIG Comment

We consider DMH's actions to be responsive and meet the intent of our recommendation.

RECOMMENDATION 10

We recommend that the Director, Department of Mental Health require the Office of Accountability to report the status of completion of all mortality reviews to the Director, Department of Mental Health on a monthly basis.

DMH Response

DMH concurred with the recommendation and plans to create a committee to monitor the efforts of OA, to include monthly reports to the Director, DMH.

OIG Comment

DMH's actions are responsive and meet the intent of our recommendation.

RECOMMENDATION 11

We recommend that the Director, Department of Mental Health require all operators of community residence facilities to retroactively report, for the time period in which the law was in effect, all unusual incidents as required and defined by D.C. Law 13-104 (from April 3, 2001 to November 14, 2001) and D.C. Law 14-70 (from February 27, 2002 to October 10, 2003), to the Inspector General of the District of Columbia.

DMH Response

DMH concurred with the recommendation and has requested CRF operators to report all unusual incidents that occurred during the period in question to the OIG.

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OIG Comment

We consider DMH's actions to be responsive and meet the intent of our recommendation.

RECOMMENDATION 12

We recommend that the Director, Department of Mental Health revise the mortality review report to reflect current organizational structure, titles, and responsibilities.

DMH Response

DMH concurred with the recommendation. See DMH actions taken in response to Recommendation # 7 above.

OIG Comment

We consider DMH's actions to be responsive and meet the intent of our recommendation.

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FINDING 3: CONTROLS OVER FORENSIC PATIENTS

SYNOPSIS

DMH's procedures for ensuring that bench warrants are issued for forensic patients on unauthorized leave are insufficient. Further, procedures for following up on the disposition of the bench warrants for missing forensic patients need improvement. Although DMH records indicated that bench warrants were requested, no documentation existed to indicate that warrants were actually issued. As a result, DMH is unaware of the status of more than 20 forensic patients, some of whom have been missing for more than 20 years.

DISCUSSION

The John Howard Pavilion, located on the campus of Saint Elizabeths Hospital, treats forensic patients and "White House Case" patients committed to DMH by a court order. A forensic patient is a patient committed under one of several statutes, including D.C. Codes §§ 24-501, 24-502, or 18 U.S.C. § 4241, for evaluation or treatment of competency or criminal responsibility. A White House Case patient is one that the U.S. Secret Service has officially declared to be dangerous to a public official, a former public official, or members of a public official's family. Both types of patients at John Howard either undergo evaluation of mental competency or have been adjudicated not guilty by reason of insanity pursuant to a prosecution for criminal charges that include rape, murder, assault, burglary, or threats against the President.

According to the John Howard Administrator, when professional medical personnel determine that patients are no longer a danger to themselves or others, they must undergo a formal hearing process before a medical review board. The medical review board is comprised of many disciplines, including the Chief Social Worker, the Chief Psychologist, and the Medical Director. If the medical review board finds the patient is no longer a danger, the findings are presented to the sentencing court. The court dictates the terms of release, which normally require psychiatric outpatient visits three times per week and daily phone contact; however, patients are seldom, if ever, granted unconditional release.

The average length of stay for patients criminally committed to Saint Elizabeths Hospital is about 20 years. Although DMH personnel maintained no formal records, we were advised that after at least 10 years, some patients are granted passes to leave the campus for short periods of time but must return the same evening.

Patients who do not return to Saint Elizabeths Hospital at the required time are placed on unauthorized leave, as provided in Department Policy 50000.524.1A. The D.C. Metropolitan

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Police Department, the U.S. Attorney's Office, or the United States Marshals Service is immediately notified of forensic patients on unauthorized leave, and a bench warrant is requested.

Documenting Bench Warrants. DMH's procedures for ensuring that bench warrants are issued for patients on unauthorized leave are insufficient. We reviewed DMH's procedures for reporting forensic patients on unauthorized leave. Our review noted DMH's procedures for notifying authorities of patients on unauthorized leave and for requesting bench warrants appeared to be adequate. However, DMH did not have procedures in place to ensure or confirm that requested bench warrants were issued. Therefore, we were unable to obtain the dates bench warrants were issued or case numbers for the bench warrant.

Discussions with DMH personnel revealed that requests for bench warrants are not confirmed in writing or verbally. As part of the audit and in an effort to determine the status of outstanding bench warrants, we provided the U.S. Attorney's Office and the D.C. Superior Court with information concerning 30 forensic patients. After coordinating with DMH management, we discovered that the Federal District court also referred forensic patients to St. Elizabeth Hospital. We have contacted the Federal District Court to obtain any additional information as to the status of missing patients.

The responses we received from both the U.S. Attorney's Office and the D.C. Superior Court indicated that they had no record of bench warrants being issued for 26 of the patients. A response from the D.C. Superior Court indicated that one of the patients had a current bench warrant issued by another state, possibly for a crime committed while the patient was on unauthorized leave from Saint Elizabeths Hospital. Most of the patients have been missing for more than 10 years.

In at least two cases, there is documentation indicating that forensic patients on unauthorized leave continue to pose a risk to themselves and others. In one case, records indicate that a former patient at the John Howard Pavilion, who was placed on unauthorized leave, is currently on death row for a homicide committed while on unauthorized leave. In a more recent case, a 60-year committed patient was charged with homicide while on unauthorized leave.

Procedures are needed at DMH to account for all forensic patients who left the custody of Saint Elizabeths Hospital on unauthorized leave. DMH should establish procedures that track the current status of requested bench warrants and provide a protocol to ensure that the status of issued bench warrants is monitored.

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RECOMMENDATIONS 13

We recommend that the Director, Department Mental Health establish procedures to confirm the issuance of all bench warrants requested for forensic patients on unauthorized leave and request the issuance of new bench warrants where appropriate.

DMH Response

DMH concurred with the recommendation and will review the procedures to verify the issuance of bench warrants and will establish appropriate mechanisms.

OIG Comment

We consider DMH's actions to be responsive and meet the intent of our recommendation.

RECOMMENDATIONS 14

We recommend that the Director, Department Mental Health negotiate a memorandum of understanding with the U.S. Attorney's Office and the Office of Corporation Counsel to confirm the issuance of bench warrants and to provide dates and case numbers for all bench warrants issued.

DMH Response

DMH concurred with the recommendation and plans to meet with the U.S. Attorneys Office, the Corporation Counsel, and the U.S. Marshall Service to determine what agreements are necessary and attainable.

OIG Comment

We consider DMH's actions to be responsive and meet the intent of our recommendation.